USE OF THIS MANUAL

The *Fee-For-Service Provider Manual* is a publication of the Arizona Health Care Cost Containment System (AHCCCS), Claims Department, Division of Fee-for-Service Management. The Claims Department also publishes *Claims Clues* as a supplement to the manual. Questions or comments related to this manual should be directed to the AHCCCS Claims Policy Unit, 701 E. Jefferson, Mail Drop 8000, Phoenix, AZ 85034.

This manual contains basic information concerning AHCCCS, Arizona's Medicaid program and the state's health care program for persons who do not qualify for Medicaid. The intent of this manual is to furnish providers' billing staff and contracted billers with information about AHCCCS, coverage of specific services, and requirements for completion and submission of fee-for-service claims to the AHCCCS Administration.

Physicians, hospital administrators, and other medical professionals may only be interested in reviewing Chapter 1 of the manual. However, providers' office staff/billers should become familiar with requirements for prior authorization, use of modifiers, recipient eligibility and enrollment, and billing policies and procedures. Use of the manual will help reduce questions about coverage of services, recipient eligibility, and proper billing procedures (including timely filing requirements) and expedite the claims process by ensuring that claims are filed correctly the first time.

This manual is only for **fee-for-service claims**. It is **not** a substitute or replacement for a health plan's or program contractor's manual. If you contract with one or more AHCCCS health plans or program contractors, please continue to follow their instructions when providing and billing for services rendered to a recipient enrolled with that health plan or program contractor.

AHCCCS OVERVIEW

The Arizona Health Care Cost Containment System was implemented on October 1, 1982, as the nation's first statewide indigent health care program designed to provide services to eligible persons primarily through a prepaid capitated managed care system. Operating as a demonstration project under the federal Medicaid program, AHCCCS receives federal, state and county funds to operate, plus some monies from Arizona's tobacco tax.

The Arizona Long Term Care System (ALTCS) was implemented December 19, 1988, for the developmentally disabled and on January 1, 1989, for the elderly and physically disabled. ALTCS provides institutional care and home and community based services to individuals who meet financial eligibility requirements and are at risk of institutionalization.

AHCCCS enrolls most eligible persons with acute care health plans and long term care program contractors. The health plans assume responsibility for the provision of all acute care covered services to enrolled recipients. The program contractors are responsible for providing and managing acute, behavioral health, and long term care services for ALTCS recipients.

NOTE: In this manual, the term "recipient" is used to describe an AHCCCS or ALTCS eligible individual who may be either fee-for-service or enrolled with a health plan or program contractor. The term "contractor" refers to both health plans and program contractors.

The contractors also are responsible for reimbursing providers for services rendered to recipients during the prior period coverage (PPC) time frame that precedes enrollment. The PPC period extends from the beginning date of an AHCCCS recipient's eligibility to the date prior to the recipient's date of enrollment with a contractor.

AHCCCS reimburses providers for services in only two ways:

1. Contractors receive a prepaid capitation payment each month to cover the cost of services provided to their enrolled members and members covered under PPC coverage. The contractors directly reimburse providers who subcontract with them.
2. AHCCCS reimburses providers on a fee-for-service basis for services rendered to recipients eligible for AHCCCS or ALTCS but not enrolled with a contractor or covered under PPC coverage.

AHCCCS **never** reimburses a recipient, even if a recipient has paid a provider for services received.

AHCCCS OVERVIEW (CONT.)

The fee-for-service population essentially consists of three groups:

- ☑ Recipients in the Federal Emergency Services (FES) program
- ☑ Recipients enrolled in Indian Health Services (IHS)
- ☑ On-reservation Native Americans enrolled with a tribal contractor

There also is a relatively small number of non-Native American recipients who, because of various reasons, will remain in permanent fee-for-service status.

The provider's primary role is to render medically necessary services to AHCCCS recipients. Prior to billing for services, the provider must be an active registered provider with AHCCCS. Providers may elect to subcontract with one or more contractors to provide services to enrolled recipients. However, the provider must be registered with AHCCCS in order to subcontract (See Exhibit 1-1 and Exhibit 1-2 for a list of contractors).

See Exhibit 1-4 for a quick reference to important telephone numbers. Further reference to these numbers is made throughout the manual.

AHCCCS-COVERED SERVICES

NOTE: The covered services, limitations, and exclusions described are global in nature and are listed here to offer general guidance to providers. Specific questions regarding covered services, limitations, and exclusions should be addressed to the AHCCCS Office of Special Programs at (602) 417-4053. The *AHCCCS Medical Policy Manual (AMPM)* also is available on the AHCCCS web site at www.ahcccs.state.az.us .

AHCCCS provides coverage for medically necessary services furnished to recipients by registered AHCCCS providers. The AHCCCS acute care program offers preventive, acute, and behavioral health care services with limited coverage of rehabilitative services, home health care and long term care, as specified in A.A.C. Title 9, Chapter 22, Articles 2 and 12. Long term care services are covered more extensively through ALTCS, as specified in A.A.C. Title 9, Chapter 28, Articles 2 and 11. Services covered under the Title XXI State Children's Health Insurance Program known as KidsCare are specified in A.A.C. Title 9, Chapter 31, Articles 2, 12, and 16. All covered services must be medically necessary and provided by a primary care provider (PCP), or other qualified provider as defined in the *AMPM*.

AHCCCS-COVERED SERVICES (CONT.)

Out-of-state services are covered as provided for under 42 CFR, Part 431, Subpart B. This includes services that, as determined on the basis of medical advice, are more readily available in other states and services needed due to a medical emergency. Services furnished to AHCCCS members outside the United States are not covered.

Medical necessity may be determined through professional review for appropriateness of services provided in conjunction with established criteria related to severity of illness and intensity of services. Documentation submitted by providers is key to the determination of medical necessity. Failure to submit documentation that substantiates medical necessity may result in denial of reimbursement.

Coverage of services is subject to AHCCCS rules, policies, and requirements, including, but not limited to:

- ☑ Prior authorization
- ☑ Concurrent review
- ☑ Claims review
- ☑ Postpayment review
- ☑ Special consent requirements

Coverage of services falls into two broad categories:

- ☑ AHCCCS acute care program
  - ✓ Preventive and acute medical care services
  - ✓ Behavioral health services
  - ✓ Limited rehabilitative services, home health care, and nursing home care
- ☑ ALTCS program
  - ✓ Preventive and acute medical care services
  - ✓ Behavioral health services
  - ✓ Long term care institutional services
  - ✓ Alternative residential living services
  - ✓ Home and community based services
  - ✓ Speech, physical, respiratory, and occupational therapies
  - ✓ Nursing services for ventilator dependent individuals residing at home

AHCCCS-COVERED SERVICES (CONT.)

Subject to exclusions and limitations addressed in the *AMPM* and AHCCCS rule, the following services are covered when medically necessary. This list is ***not*** all-inclusive. Further information on coverage, limitations, and authorization requirements can be found in specific chapters of this manual.

- ☑ Behavioral health services (emergency crisis stabilization)
- ☑ Dental services (limited for adults)
- ☑ Dialysis services
- ☑ Emergency services
- ☑ Eye examinations and optometry services
- ☑ Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for individuals under age 21
- ☑ Family planning
- ☑ Health risk assessments and screening tests
- ☑ Home health services
- ☑ Hysterectomy services
- ☑ Immunizations
- ☑ Inpatient hospital services
- ☑ Laboratory, radiology, and medical imaging services
- ☑ Maternal and child health services
- ☑ Medical supplies, durable medical equipment, and orthotic/prosthetic devices
- ☑ Observation services
- ☑ Organ transplants and related immunosuppressant drugs
- ☑ Podiatry services
- ☑ Prescription drugs
- ☑ Physician services
- ☑ Radiology and medical imaging
- ☑ Rehabilitation therapies
- ☑ Transportation

AHCCCS-COVERED SERVICES (CONT.)

In addition to the acute services listed on the previous page, the following ALTCS services are covered when medically necessary and authorized, subject to exclusions and limitations addressed in the *AMPM* and AHCCCS rule. This list is ***not*** all-inclusive.

- ☑ Case management services
- ☑ Institutional services
- ☑ Home and community based services

The following behavioral health services also are covered under ALTCS when medically necessary and authorized, if appropriate. This list is ***not*** all-inclusive.

- ☑ Evaluation, diagnostic and case management services
- ☑ Institutional services
- ☑ Professional services
- ☑ Rehabilitation services

NON-COVERED SERVICES

AHCCCS does not pay for services that are provided free to the recipient, such as free chest X-rays provided by a voluntary health organization and free samples or items received for use in studies or as starter doses. The following list of other non-covered services is *not* all-inclusive. To obtain specific information, consult the *AMPM* and AHCCCS rule or contact the AHCCCS Office of Special Programs at (602) 417-4053.

Services *not* covered by AHCCCS include:

- ☑ Services mandated for purposes of meeting non-medical requirements, such as employment physicals and physician visits required for a license or certificate
- ☑ Services provided by or under the direction of naturopaths
- ☑ Personal comfort items and services
- ☑ Cosmetic surgery intended solely to improve the physical appearance of a recipient

NON-COVERED SERVICES (CONT.)

Services *not* covered by AHCCCS include (Cont.):

- ☑ Reconstructive surgical procedures intended to improve function and appearance of any body part or organ which has been altered by disease, trauma, congenital or developmental anomalies or previous surgical processes unless the services are medically necessary
  - ✓ Clear and precise documentation substantiating medical necessity for reconstructive surgery is required for a covered service determination.
- ☑ Therapeutically induced abortions and abortion counseling unless:
  - ✓ The pregnant member suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated, or
  - ✓ The pregnancy is a result of rape or incest, or
  - ✓ The pregnancy termination is medically necessary according to the medical judgment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member by:
    - ☒ Creating a serious physical or mental health problem for the pregnant member, or
    - ☒ Seriously impairing a bodily function of the pregnant member, or
    - ☒ Causing dysfunction of a bodily organ or part of the pregnant member, or
    - ☒ Exacerbating a health problem of the pregnant member, or
    - ☒ Preventing the pregnant member from obtaining treatment for a health problem.
- ☑ Penile implants for recipients over 21 years of age
- ☑ Hearing aids, except as allowed under EPSDT for recipients under 21 and for KidsCare recipients under age 19
- ☑ Eye exams and eyeglasses, except as allowed under EPSDT for recipients under 21 and for KidsCare recipients under age 19
  - ✓ Eyeglasses and contact lenses are not excluded if they are the sole prosthetic device after cataract extraction.
- ☑ Routine dental care, except as allowed under EPSDT for recipients under 21 and for KidsCare recipients under age 19
- ☑ Routine circumcision for newborn males

NON-COVERED SERVICES (CONT.)

Services *not* covered by AHCCCS include (Cont.):

- ☑ Norplant insertion
- ☑ Services determined to be experimental or provided primarily for the purpose of research
- ☑ Artificial or mechanical hearts or xenografts
- ☑ Services provided to residents of a tuberculosis or behavioral health treatment institution
- ☑ Treatment for drug abuse unless authorized in rule
- ☑ Outpatient occupational and speech therapy except as allowed under EPSDT, ALTCS, and KidsCare